Employee ID #: 8 1 _ _ _ _ _ _ _

Maricopa County

Group Insurance Qualified Status Change Form

Required Information

Complete this form within 30 days of a Qualified Status Change and deliver it to the Benefits Office or your HR Liaison.

Please Print

Employee Demographic Information Section

Last Name	First Name	Middle Initial	Date of Birth

Gender	Social Security #	Alternate ID # Request	Martial Status	Dept. Name
❑ Male ❑ Female	(Voluntary)	❑ No ❑ Yes (Must submit Alternate ID # Request Form)	❑ Single ❑ Married ❑ Divorced ❑ Widow	

Mailing Address	City	State	Zip
		AZ	

E-mail Address	Home Phone #	Work Phone #	Mobile Phone #

Emergency Contact Name	Emergency Contact Phone #	Emergency Contact Address

CHANGE REASON SECTION (Please Check One Reason to Explain Your Status Change)

❑ Marriage ❑ Birth ❑ Adoption ❑ Placement for adoption ❑ Legal guardianship of child ❑ Qualified Medical Child Support order ❑ Change in legal custody	❑ Divorce ❑ Annulment ❑ Legal separation ❑ Death of _____ ❑ Dependent child reaches age 19 ❑ Dependent student ❑ Began full-time higher education ❑ Ended full-time higher education ❑ Reaches age 25	❑ Termination of employment ❑ Commencement of employment ❑ Change in hours/ status results in attaining benefit eligibility ❑ Change in hours/status results in loss of benefit eligibility ❑ Significant cost or benefit change in spouse's employer group insurance plan (open enrollment ❑ Other _____	❑ Began unpaid leave of absence ❑ Medical ❑ Personal ❑ Military ❑ Return from unpaid leave ❑ Return from military leave ❑ Attained eligibility for ❑ Medicare ❑ AHCCCS/Medicaid

DATE OF CHANGE:__/__/____	If employment change, is change for ❑ employee or ❑ spouse?
WHAT ACTION ARE YOU REQUESETING?	❑ Add dependent? ❑ Drop dependent? ❑ Drop or decline coverage for employee? ❑Other?_____

WAIVE MEDICAL COVERAGE/REQUEST MEDICAL WAIVER PAYMENT/ELECT VISION ONLY FOR WAIVER SECTION

❑ WAIVE MEDICAL Reason:_____

❑ REQUEST MEDICAL WAIVER PAYMENT To qualify for waiver payment, you must provide a copy of your current group health insurance ID card to the Benefits Office and work a minimum of 30 hours per week. Coverage under AHCCCS does not qualify for waiver payment. You may elect Vision Only coverage if you waive medical coverage.

❑ Elect Vision Only for Waiver

Level of Coverage for Vision Only for Waiver

❑ Employee ❑ Employee & Child(ren)
❑ Employee & Spouse ❑ Family

ELECT A MEDICAL PLAN SECTION

Medical plans include vision and behavioral health coverage. Please choose a medical plan and the level of coverage

❑ HealthSelect ❑ CIGNA HMO CMG High Option (Coverage restricted to CIGNA clinics) ❑ CIGNA HMO CMG Low Option (Coverage restricted to CIGNA clinics)	❑ CIGNA HMO IPA ❑ CIGNA OAP High Option ❑ CIGNA OAP Low Option ❑ CIGNA Choice Fund High Deductible Health Plan with Optional Health Savings Account (HSA)	Level of Coverage ❑ Employee ❑ Employee & Spouse ❑ Employee & Child(ren) ❑ Family

TOBACCO USER* ❑ Yes ❑ No *Applies to Employee Only	If you enroll in a medical plan, you must indicate if you are a tobacco user. If you leave this question blank, it will be assumed that you are a tobacco user and you will be charged a higher premium rate. Tobacco user means the occasional or regular use of a tobacco product including but not limited to cigarettes, cigars, pipes, snuff, chewing tobacco and any other product containing tobacco. If you have used any tobacco products in the last 6 consecutive months, you must choose Tobacco User-Yes.

ELECT A PHARMACY PLAN SECTION

You must choose one Rx Plan to accompany your elected Medical Plan unless you enrolled in CIGNA Choice Fund. In this case do not make an election.

❑ Co-Insurance Plan ❑ Consumer Choice Plan

ELECT A DENTAL PLAN SECTION

❑ DECLINE DENTAL PLANS

You may elect dental coverage even if you decline medical coverage.

❑ Employers Dental Services	❑ CIGNA Dental	❑ Delta Dental	Dental Level of Coverage ❑ Employee ❑ Employee & Spouse	❑ Employee & Child(ren) ❑ Family

Employee ID #: 8 1 __ __ __ __ __ __ __

Eligible dependents include:

- Legal spouse as defined by the State of Arizona (Domestic partners/significant others/common law spouses are not eligible)
- Unmarried child (natural child, stepchild, legally adopted child, child placed with you for adoption or child for whom you have been awarded legal guardianship) under age 19 who resides with you more than 50% of the tax year (Qualified Medical Child Support Orders or other court/administrative orders do not violate this residency rule) and for whom you have or will provide more than 50% of his/her support during the tax year
- Unmarried child, of any age, who resides with you for more than 50% of the tax year and is medically certified as disabled prior to age 19 or age 24 if disabled while a full-time student and for whom you have or will provide more than 50% of his/her support during the tax year. If age 24 or older, the dependent child cannot have a gross income in excess of the IRS exemption amount.
- Unmarried child between the ages of 19 and 24, or age 24 if gross income is not in excess of the IRS exemption amount, who resides with you for more than 50% of the tax year (temporary absences due to school attendance do not violate this residency rule), is a full-time student, as defined by the accredited institution of higher education and for whom you have or will provide more than 50% of his/her support during the tax year. You must supply the Benefits Office with documentation from the school verifying full-time student status. (Your student dependent child remains eligible during summer breaks from school provided that he/she will be attending school on a full-time basis during the fall term/semester.)

DEPENDENT/BENEFICIARY INFORMATION SECTION

In this section, you can add or drop dependents for your Medical and Pharmacy (Rx) Plan and/or for your dental plan. Please make sure you are adding eligible dependents as defined above. You must submit documentation of your status change, such as birth certificate for a newborn child, marriage certificate, divorce decree, student status verification, job status change, etc. You may also add or change your life insurance beneficiary in this section. If you have more than 4 dependents or beneficiaries, you may add them by photocopying, completing and attaching an additional copy of this page to your form.

1. ❑Add or ❑Drop Dependent for: ❑ Medical & Rx Plan ❑ Dental Plan				❑Add or ❑Change Life Beneficiary		
RELATIONSHIP	❑ Legal Spouse ❑ Child (under 19)	❑ Full-Time Student (19 & older) ❑ Disabled Child (19 & older)	❑ Child with Legal Guardianship	❑ Father ❑ Mother	❑ Sister ❑ Brother	❑ Friend
Social Security # (Voluntary)	Last Name	First Name	Date of Birth			Gender ❑ Male ❑ Female
Mailing Address ❑ Same as employee's		City		State		Zip

2. ❑Add or ❑Drop Dependent for: ❑ Medical & Rx Plan ❑ Dental Plan				❑Add or ❑Change Life Beneficiary		
RELATIONSHIP	❑ Legal Spouse ❑ Child (under 19)	❑ Full-Time Student (19 & older) ❑ Disabled Child (19 & older)	❑ Child with Legal Guardianship	❑ Father ❑ Mother	❑ Sister ❑ Brother	❑ Friend
Social Security # (Voluntary)	Last Name	First Name	Date of Birth			Gender ❑ Male ❑ Female
Mailing Address ❑ Same as employee's		City		State		Zip

3. ❑Add or ❑Drop Dependent for: ❑ Medical & Rx Plan ❑ Dental Plan				❑Add or ❑Change Life Beneficiary		
RELATIONSHIP	❑ Legal Spouse ❑ Child (under 19)	❑ Full-Time Student (19 & older) ❑ Disabled Child (19 & older)	❑ Child with Legal Guardianship	❑ Father ❑ Mother	❑ Sister ❑ Brother	❑ Friend
Social Security # (Voluntary)	Last Name	First Name	Date of Birth			Gender ❑ Male ❑ Female
Mailing Address ❑ Same as employee's		City		State		Zip

4. ❑Add or ❑Drop Dependent for: ❑ Medical & Rx Plan ❑ Dental Plan				❑Add or ❑Change Life Beneficiary		
RELATIONSHIP	❑ Legal Spouse ❑ Child (under 19)	❑ Full-Time Student (19 & older) ❑ Disabled Child (19 & older)	❑ Child with Legal Guardianship	❑ Father ❑ Mother	❑ Sister ❑ Brother	❑ Friend
Social Security # (Voluntary)	Last Name	First Name	Date of Birth			Gender ❑ Male ❑ Female
Mailing Address ❑ Same as employee's		City		State		Zip

5. ❑Add or ❑Drop Dependent for: ❑ Medical & Rx Plan ❑ Dental Plan				❑Add or ❑Change Life Beneficiary		
RELATIONSHIP	❑ Legal Spouse ❑ Child (under 19)	❑ Full-Time Student (19 & older) ❑ Disabled Child (19 & older)	❑ Child with Legal Guardianship	❑ Father ❑ Mother	❑ Sister ❑ Brother	❑ Friend
Social Security # (Voluntary)	Last Name	First Name	Date of Birth			Gender ❑ Male ❑ Female
Mailing Address ❑ Same as employee's		City		State		Zip

Employee ID #: 8 1 _ _ _ _ _ _ _

Maricopa County

Group Insurance Qualified Status Change Form

LIFE INSURANCE SECTION

Please make sure that you have fully completed the date of birth, gender and mailing address information for each beneficiary on page 2 in the Dependent/Beneficiary Information Section.

BASIC LIFE with Accidental Death & Dismemberment (AD&D) 1 X Salary (Paid 100% by Maricopa County)

Beneficiary Designation Your spouse is entitled to 50% of the value of your basic &/or supplemental life policy unless your spouse signs a spousal waiver located on the Beneficiary Designation form.

Primary Beneficiary	Whole Percentage (Must add up to 100%)	Contingent (Secondary) Beneficiary	Whole Percentage (Must add up to 100%)
1.		1.	
2.		2.	
3.		3.	

VOLUNTARY SUPPLEMENTAL LIFE with AD&D

(Paid 100% by Employee)

❑ Smoker
❑ Non-Smoker

❑ DECLINE SUPPLEMENTAL LIFE

Plan Level Options Please Choose One ➔

❑ 1 X Salary ❑ 2 X Salary ❑ 3 X Salary ❑ 4 X Salary ❑ 5 X Salary

Primary Beneficiary	Whole Percentage (Must add up to 100%)	Contingent (Secondary) Beneficiary	Whole Percentage (Must add up to 100%)
1. ❑ Same as above	❑ Same as above	1. ❑ Same as above	❑ Same as above
2. ❑ Same as above	❑ Same as above	2. ❑ Same as above	❑ Same as above
3. ❑ Same as above	❑ Same as above	3. ❑ Same as above	❑ Same as above

VOLUNTARY DEPENDENT LIFE (Paid100% by Employee)

❑ DECLINE DEPENDENT LIFE

❑ Legal spouse covered $5,000 and each dependent child* from 14 days up covered for $2,500
❑ Legal spouse covered $10,000 and each dependent child* from 14 days up covered for $5,000
*See Eligible Dependent Section for age limits

VOLUNTARY HEALTH CARE FLEXIBLE SPENDING ACCOUNT (FSA)

The Health Care Flexible Spending Account (FSA) pays for certain health care expenses not covered by insurance. The Plan Year contribution is limited to $5,200. The full Plan Year has 26 pay periods and runs from Jan. 1-Dec. 31. Enter the amount (Annual Pledge) you are electing for the remainder of the calendar year. Your Annual Pledge will be divided by the number of pay periods remaining in the calendar year after your election has been processed. If you terminate employment prior to the end of the Plan Year, your Plan Year ends on the last day of the pay period in which you made a contribution. You can elect to continue this benefit through COBRA through the end of the current calendar year. You may not enroll in the Health Care FSA if you are enrolled in the CIGNA Choice Fund High Deductible Health Plan or have other health insurance such as Medicare and have a Health Savings Account.

❑ Add FSA ❑ Drop FSA ❑ Change FSA **Amount $_____Annual Pledge**

VOLUNTARY CHILD DAY CARE or ELDER CARE FLEXIBLE SPENDING ACCOUNT (FSA)

The Dependent Care Flexible Spending Account (FSA) pays for dependent care (childcare or elder day care) expenses. Plan Year contributions are limited to $5,000. However, if you are married and file a separate tax return, the maximum annual contribution is limited to $2,500 or the lesser of your earned incomes. The full Plan Year has 26 pay periods and runs from Jan. 1-Dec. 31. Enter the amount (Annual Pledge) you are electing for the remainder of the calendar year. Your Annual Pledge will be divided by the number of pay periods remaining in the calendar year after your election has been processed. If you terminate employment prior to the end of the Plan Year, your Plan Year ends on the last day of the pay period in which you made a contribution. This benefit may not be continued through COBRA. Please note this benefit may not be used to cover your dependents' health care expenses.

❑ Add FSA ❑ Drop FSA ❑ Change FSA **Amount $_____Annual Pledge**

Please Indicate Tax Status	❑ Single	❑ Married filing Jointly	❑ Married filing Separately

Employee ID #: 8 1 __ __ __ __ __ __ __

AUTHORIZATION

I authorize Maricopa County to take deductions from my paycheck) to pay for my benefit costs. I also authorize the Benefits Office to send necessary personal information to my selected vendors to initiate and support my coverage.

By submitting my open enrollment request or continuing with my current health care coverage, I understand and agree that Maricopa County may share protected health information (PHI) concerning me and my dependents, as described in the Maricopa County Notice of Privacy Practices, with my health care providers which could include CIGNA HealthCare of AZ and CIGNA Dental, HealthSelect, Walgreens Health Initiatives (WHI), United Behavioral Health (UBH), Delta Dental, Employers Dental Services (EDS), UnumProvident Life, AVESIS, VPA, Inc., Application Software Inc. (the flexible spending account administrator) and WHI in its role as Pharmacy Benefits Manager. I further agree to release Maricopa County and Maricopa County's health care providers from any liability for any good faith release of PHI in connection with my benefits or as otherwise authorized or required by law.

I certify to the best of my knowledge all information I have provided is accurate, correct and complete. I understand that I may be subject to disciplinary action up to and including termination for failing to provide accurate and complete information. I further understand and agree that I will be required to reimburse Maricopa County for any additional premiums owed as a result of providing inaccurate, incorrect and/or incomplete information.

Employee Signature: _____ Date: _____

FOR OFFICE USE ONLY

Effective Date:	Benefits Coordinator Initials
	Date Processed by Benefits Coordinator

DELIVERY INSTRUCTIONS

This form is used to report qualified status changes. This form may not be used for new or rehire enrollments. These enrollments must be completed online through Employee Self Service in PeopleSoft. Deliver this form to the Employee Health Initiatives Benefits Office or to your Department's Human Resources (HR) Liaison or fax to 602-506-2354. Please keep a copy of your status change form containing a date stamp from the Benefits Office or from your HR Liaison. If faxing, please keep a copy of your fax confirmation. Do not deliver via interoffice mail, unless your form has been date-stamped by your Department's HR Liaison. You may mail your form via U.S. Postal Service if it is postmarked no later than 30 days from the date of your qualified status change.

CONTACT INFORMATION

Maricopa County Employee Health Initiatives, Employee Benefits Office
301 West Jefferson, Suite 201, Phoenix, AZ 85003
Phone: 602-506-1010 Fax: 602-506-2354
Email: BenefitsService@mail.maricopa.gov
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